

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

File No. 100169-001

v

Blue Cross Blue Shield of Michigan

Respondent

Issued and entered
this 24th day of November 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 15, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901, *et seq.* The Commissioner reviewed the request and accepted it on September 22, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on October 1, 2008.

The Petitioner's group health care coverage is defined by the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The issue in this external review can be decided by an analysis of this contract. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II FACTUAL BACKGROUND

On October 9, 2007, the Petitioner underwent umbilical hernia repair. She also had a mammoplasty with a prosthetic implant. These services were provided by XXXXX, MD, at the XXXXX Plastic Surgery Center, an ambulatory surgery facility, in XXXXX. BCBSM reimbursed the Petitioner for the surgeon's fees but later requested a refund from the Petitioner of the \$546.01 it paid for the mammoplasty. BCBSM also requested a refund of the \$351.84 it paid to the ambulatory surgery facility for the facility fee related to the hernia surgery.

The Petitioner appealed the amount BCBSM paid and its request for refunds. BCBSM held a managerial-level conference on August 29, 2008, and issued a final adverse determination dated September 3, 2008. The Petitioner exhausted BCBSM's internal grievance process and seeks review by the Commissioner under PRIRA.

III ISSUE

What is the correct amount BCBSM is required to pay for the Petitioner's October 9, 2007, surgery?

IV ANALYSIS

Petitioner's Argument

The Petitioner says that she had hernia surgery that was a covered benefit under her BCBSM certificate. The Petitioner also had personal plastic (cosmetic) surgery provided on the same day as her hernia surgery that she says "got mixed up in the claim." She believes that BCBSM has not paid the proper amount for her surgery and is not totally justified in requesting a refund.

BCBSM's Argument

The amount charged and the amount paid by BCBSM for professional fees for the

Petitioner's October 9, 2007, surgeries are as follows:

Description	Amount Charged by Surgeon	BCBSM's Approved Amount	Out of Network Sanctions	Amount Paid by BCBSM
Hernia Repair	\$1,200.00	\$219.90	\$203.98	\$15.92
Mammoplasty with Implant	\$3,800.00	\$682.51	\$136.50	\$546.01
Supplies & Materials	\$1,000.00	\$0.00*		\$0.00
Periprosthetic Capsulectomy	\$1,000.00	\$0.00*		\$0.00
Anesthesia	\$680.00	\$367.50		\$367.50

*Payment was denied since it was included in the payment for a related service performed on the same day

The facility fees for the Petitioner's surgery are as follows:

Description	Amount Charged by Facility	BCBSM's Approved Amount	Out of Network Sanctions	Amount Paid by BCBSM
Facility Fee (hernia)	\$1,000.00	\$439.80	\$87.96	\$351.84
Facility Fee (mammoplasty)	\$3,800.00	\$0.00**		\$0.00
Facility Fee (capsulectomy)	\$1,800.00	\$0.00**		\$0.00

** Payment was denied since the facility does not participate with BCBSM

The only surgery the Petitioner received that was payable was the hernia repair. BCBSM initially processed the claims for the hernia repair and the mammoplasty together and, based on its rules for multiple surgeries, approved half of its maximum payment level for the hernia repair. However, after it determined that the mammoplasty was cosmetic in nature and therefore not a covered benefit, BCBSM recognized that it should therefore have approved the full maximum of \$439.80 for the hernia surgery instead of \$219.90.

BCBSM says that after applying the out-of network sanctions of \$203.98 (\$200.00 deductible and 20% coinsurance of \$3.98), an additional \$235.82 ($\$439.80 - \$203.98 = \$235.82$) should have been paid for physician fees for the Petitioner's hernia surgery. Since BCBSM paid \$546.01 in error for the physician fees for the mammoplasty, BCBSM the Petitioner must refund for the difference of \$310.68.

BCBSM says it also paid the facility fee related to the Petitioner's hernia surgery in error.

The certificate says on page 3.32:

We pay for medically necessary facility services provided by a BCBSM participating ambulatory surgery facility. [Emphasis supplied]

In the Petitioner's case, the surgeries were performed at a nonparticipating ambulatory surgery facility. Therefore, the \$351.84 facility fee BCBSM paid for the hernia surgery was paid in error and BCBSM has asked the facility to refund this payment.

Commissioner's Review

The certificate describes how benefits are paid. On page 4.2, the certificate says that BCBSM pays its "approved amount" for physician and other professional services. The approved amount is defined on page 7.2 as "the lower of the billed charge or [BCBSM's] maximum payment level for the covered service."

BCBSM's participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full. Section 4 of the certificate, "How Physician and Other Professional Provider Services Are Paid," explains this (page 4.29):

If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .

NOTE: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate also states that if the provider is not part of the BCBSM panel then a \$250 deductible and a 20% copayment is applied. Since Dr. XXXXX does not participate with BCBSM he also is not part of the BCBSM panel and the non-panel deductible and copayment sanctions apply.

Cosmetic surgery is specifically excluded in the certificate. The Petitioner did not dispute BCBSM's assertion that her mammoplasty was cosmetic surgery and therefore not a covered benefit. Consequently, BCBSM's payment of the surgeon's fee for the mammoplasty was an error.

Care in a freestanding ambulatory surgery facility is a covered benefit under the certificate

only if the facility participates with BCBSM. In the Petitioner's case the facility is not participating so the facility charges are not a covered benefit. Therefore, the \$351.84 that was paid to the provider was made in error and BCBSM recouped this amount from the provider.

Finally, BCBSM erred when it paid the surgeon's fee for the Petitioner's hernia repair as if it was the minor surgery in a multiple procedure – it based its reimbursement on one half of the maximum payment for the procedure. BCBSM acknowledged its error and has authorized its full approved amount for the physician's fee for the hernia repair.

The Commissioner finds that BCBSM overpaid the Petitioner \$546.01 for her mammoplasty surgery and underpaid her hernia repair surgery by \$235.82. Based on these figures, the Petitioner was overpaid a total of \$310.19 for her October 9, 2007, surgery ($\$546.01 - \$235.82 = \$310.19$). Since BCBSM paid its approved amounts for these services directly to the Petitioner, BCBSM is then entitled to collect this overpayment from her.

V ORDER

BCBSM's revised final adverse determination is upheld. BCBSM is entitled to seek repayment of \$310.19 from the Petitioner for her October 9, 2007, surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.